Senate

General Assembly

File No. 626

January Session, 2011

Senate Bill No. 921

Senate, April 26, 2011

The Committee on Finance, Revenue and Bonding reported through SEN. DAILY of the 33rd Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) For purposes of sections 1 to 12, inclusive, of this act:

(1) "Board" means the board of directors of the Connecticut Health Insurance Exchange;

(2) "Commissioner" means the Insurance Commissioner;

(3) "Exchange" means the Connecticut Health Insurance Exchange established pursuant to section 2 of this act;

(4) "Federal act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and regulations adopted thereunder;

(5) (A) "Health benefit plan" means an insurance policy or contract offered, delivered, issued for delivery, renewed, amended or continued in the state by a health carrier to provide, deliver, pay for or reimburse any of the costs of health care services.

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5), (6), (7), (8), (9), (14), (15) and (16) of section 38a-469 of the general statutes or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate insurance policy, certificate or contract or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof; or

(iii) Other similar, limited benefits specified in regulations issued

pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time;

(iv) Other supplemental coverage, similar to coverage of the type specified in subdivisions (9) and (14) of section 38a-469 of the general statutes, provided under a group health plan.

(D) "Health benefit plan" does not include coverage of the type specified in subdivisions (3) and (13) of section 38a-469 of the general statutes or other fixed indemnity insurance if (i) such coverage is provided under a separate insurance policy, certificate or contract, (ii) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (iii) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained by the same plan sponsor;

(6) "Health care services" has the same meaning as provided in section 38a-478 of the general statutes;

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

(8) "Internal Revenue Code" means the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time;

(9) "Person" has the same meaning as provided in section 38a-1 of the general statutes;

(10) "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection (e) of section 8 of this act;

(11) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided the employer:

(A) Has its principal place of business in the state and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in the state;

(12) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the federal act and section 8 of this act;

(13) "Qualified individual" means an individual, including a minor, who:

(A) Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(B) Resides in the state;

(C) Is not incarcerated, other than incarceration pending the disposition of charges, at the time of enrollment; and

(D) Is, and is reasonably expected to be, a citizen or national of the United States or an alien lawfully present in the United States, for the entire period for which enrollment is sought;

(14) "Secretary" means the Secretary of the United States Department of Health and Human Services;

(15) "SHOP Exchange" means the Small Business Health Options Program established pursuant to subdivision (10) of section 6 of this act;

(16) (A) "Small employer" means an employer that employed an average of not more than fifty employees in the state during the preceding calendar year.

(B) For purposes of this subdivision:

(i) All persons treated as a single employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that is reasonably expected such employer will employ on business days in the current calendar year; and

(v) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of sections 1 to 12, inclusive, of this act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Sec. 2. (NEW) (*Effective from passage*) (a) There is hereby created as a body politic and corporate, constituting a public instrumentality and political subdivision of the state created for the performance of an essential public and governmental function, to be known as the Connecticut Health Insurance Exchange. The Connecticut Health Insurance Exchange shall not be construed to be a department, institution or agency of the state.

(b) The powers of the exchange shall be vested in and exercised by a board of directors, which shall consist of thirteen voting members. The appointment of the initial board members shall be as follows:

(1) The Governor shall appoint four board members, one of whom shall be a representative of small employers and shall serve for a term of four years, one of whom shall be a representative of labor and shall serve for a term of three years, one of whom shall be a representative of health care providers and shall serve for a term of two years, and one of whom shall be a representative of health care consumers and shall serve for a term of one year;

(2) The president pro tempore of the Senate shall appoint one board member who shall be an actuary and shall serve for a term of four years;

(3) The speaker of the House of Representatives shall appoint one board member who shall be a health plan benefit specialist and shall serve for a term of three years;

(4) The majority leader of the Senate shall appoint one board member who shall be a health care economist and shall serve for a term of two years;

(5) The majority leader of the House of Representatives shall appoint one board member who shall be a representative of self-employed individuals and shall serve for a term of one year;

(6) The minority leader of the Senate shall appoint one board member who shall be a representative of large employers and shall serve for a term of four years;

(7) The minority leader of the House of Representatives shall appoint one board member who shall be a representative of the health insurance industry and shall serve for a term of three years;

(8) The Commissioners of Public Health and Social Services, or their designees, shall serve as ex-officio voting board members;

(9) The Secretary of the Office of Policy and Management, or the secretary's designee, shall serve as an ex-officio voting board member; and

(10) The Insurance Commissioner, or the commissioner's designee, shall serve as an ex-officio nonvoting board member.

(c) All initial appointments shall be made not later than July 1, 2011. Following the expiration of such initial terms, subsequent board member terms shall be for four years. Any vacancy shall be filled by the appointing authority for the balance of the unexpired term. Any member of the board may be removed by the appropriate appointing authority for misfeasance, malfeasance or wilful neglect of duty.

(d) The Governor shall select a chairperson from among the board members. The chairperson shall schedule the first meeting of the board, which shall be held not later than August 1, 2011. Any board member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the board.

(e) Board members shall receive no compensation for their services but shall receive actual and necessary expenses incurred in the performance of their official duties.

(f) Board members may engage in private employment or in a profession or business, subject to any applicable laws, rules and regulations of the state or federal government regarding official ethics or conflicts of interest.

(g) Notwithstanding any provision of the general statutes, it shall not constitute a conflict of interest for a trustee, director, partner or officer of any person, firm or corporation, or any individual having a financial interest in a person, firm or corporation, to serve as a board member of the exchange, provided such trustee, director, partner, officer or individual shall abstain from deliberation, action or vote by the exchange in specific request to such person, firm or corporation.

(h) The board shall select and appoint a chief executive officer who shall be responsible for administering the exchange's programs and activities in accordance with policies and objectives established by the board. The chief executive officer shall serve at the pleasure of the board and shall receive such compensation as shall be determined by the board. The chief executive officer (1) may employ such other employees as shall be designated by the board of directors, and (2) shall attend all meetings of the board, keep a record of all proceedings and maintain and be custodian of all records, books, documents and papers filed with or compiled by the exchange.

(i) The board may consult with such parties, public or private, as it deems desirable or necessary in exercising its duties under sections 1 to 12, inclusive, of this act.

(j) The board may create such advisory committees as it deems necessary to provide input on issues that may include, but not be limited to, customer service needs and insurance agent and broker concerns.

Sec. 3. (NEW) (*Effective from passage*) The board of directors of the exchange shall adopt written procedures, in accordance with the provisions of section 1-121 of the general statutes, for: (1) Adopting an annual budget and plan of operations, including a requirement of board approval before the budget or plan may take effect; (2) hiring, dismissing, promoting and compensating employees of the exchange, including an affirmative action policy and a requirement of board approval before a position may be created or a vacancy filled; (3) acquiring real and personal property and personal services, including a requirement of board approval for any nonbudgeted expenditure in excess of five thousand dollars; (4) contracting for financial, legal, bond underwriting and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each such service which it uses; (5) issuing and retiring bonds, bond anticipation notes and other obligations of the authority; (6) establishing requirements for certification of qualified health plans that

include, but are not limited to, minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and quality measures for health benefit plan performance; and (7) implementing the provisions of sections 1 to 12, inclusive, of this act or other provisions of the general statutes. Any such written procedures adopted pursuant to subdivision (7) of this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the federal act.

Sec. 4. (NEW) (*Effective from passage*) The board of directors of the exchange shall submit to the joint standing committee of the General Assembly having cognizance of matters relating to insurance a copy of each audit of the exchange conducted by an independent auditing firm, not later than seven days after the audit is received by said board of directors.

Sec. 5. (NEW) (*Effective from passage*) (a) For purposes of sections 1 to 12, inclusive, of this act, "purposes of the exchange" means the purposes of the exchange expressed in and pursuant to this section, which are hereby determined to be public purposes for which public funds may be expended. The powers enumerated in this section shall be interpreted broadly to effectuate the purposes of the exchange and shall not be construed as a limitation of powers.

(b) The exchange is authorized and empowered to:

(1) Have perpetual successions as a body politic and corporate and to adopt bylaws for the regulation of its affairs and the conduct of its business;

(2) Adopt an official seal and alter the same at pleasure;

(3) Maintain an office in the state at such place or places as it may designate;

(4) Employ such assistants, agents and other employees as may be

necessary or desirable, which employees shall be exempt from the classified service and shall not be employees, as defined in subsection (b) of section 5-270 of the general statutes;

(5) Establish all necessary or appropriate personnel practices and policies, including those relating to hiring, promotion, compensation, retirement and collective bargaining, which need not be in accordance with chapter 68 of the general statutes, and the exchange shall not be an employer, as defined in subsection (a) of section 5-270 of the general statutes;

(6) Engage consultants, attorneys and other experts as may be necessary or desirable to carry out the purposes of the exchange;

(7) Acquire, lease, purchase, own, manage, hold and dispose of real and personal property, and lease, convey or deal in or enter into agreements with respect to such property on any terms necessary or incidental to the carrying out of these purposes;

(8) Receive and accept, from any source, aid or contributions, including money, property, labor and other things of value;

(9) Charge assessments or user fees to health carriers or otherwise generate funding necessary to support the operations of the exchange;

(10) Procure insurance against loss in connection with its property and other assets in such amounts and from such insurers as it deems desirable;

(11) Invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state and in obligations that are legal investments for savings banks in the state;

(12) Issue bonds, bond anticipation notes and other obligations of the exchange for any of its corporate purposes, and to fund or refund the same and provide for the rights of the holders thereof, and to secure the same by pledge of revenues, notes and mortgages of others;

(13) Borrow money for the purpose of obtaining working capital;

(14) Account for and audit funds of the exchange and any recipients of funds from the exchange;

(15) Make and enter into any contract or agreement necessary or incidental to the performance of its duties and execution of its powers. The contracts entered into by the exchange shall not be subject to the approval of any other state department, office or agency, provided copies of all contracts of the exchange shall be maintained by the exchange as public records, subject to the proprietary rights of any party to the contract;

(16) To the extent permitted under its contract with other persons, consent to any termination, modification, forgiveness or other change of any term of any contractual right, payment, royalty, contract or agreement of any kind to which the exchange is a party;

(17) Award grants to Navigators as described in subdivision (15) of section 6 of this act. Applications for grants from the exchange shall be made on a form prescribed by the board. The board shall review applications and decide whether to award a grant. The board may consider, as a condition for awarding a grant, the potential grantee's financial participation and any other factors the board deems relevant;

(18) Sue and be sued, plead and be impleaded;

(19) Adopt regular procedures that are not in conflict with other provisions of the general statutes, for exercising the power of the exchange; and

(20) Do all acts and things necessary and convenient to carry out the purposes of the exchange.

Sec. 6. (NEW) (*Effective from passage*) The exchange shall:

(1) Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary

under Section 1311(c) of the federal act, and section 8 of this act, of health benefit plans as qualified health plans;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Provide for enrollment periods, as provided under Section 1311(c)(6) of the federal act;

(4) Maintain an Internet web site through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(5) Publish the average costs of licensing, regulatory fees and any other payments required by the exchange and the administrative costs of the exchange, including information on monies lost to waste, fraud and abuse, on an Internet web site to educate individuals on such costs;

(6) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the federal act;

(7) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the Public Health Service Act, 42 USC 300gg-15, as amended from time to time;

(8) Inform individuals, in accordance with Section 1413 of the federal act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, as amended from time to time, or any applicable state or local public program, and enroll an individual in such program if the exchange determines, through screening of the application by the exchange, that such individual is eligible for any

such program;

(9) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code and any cost-sharing reduction under Section 1402 of the federal act;

(10) Establish a Small Business Health Options Program (SHOP) Exchange through which qualified employers may access coverage for their employees and that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(11) Grant a certification, subject to Section 1411 of the federal act, attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code, an individual is exempt from the individual responsibility requirement or from the penalty imposed by said Section 5000A because:

(A) There is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(12) Provide to the Secretary of the Treasury of the United States the following:

(A) A list of the individuals granted a certification under subdivision (11) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code because:

(i) The employer did not provide minimum essential health benefits coverage; or

(ii) The employer provided the minimum essential coverage but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to be unaffordable to the employee or not provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of:

(i) Each individual who notifies the exchange under Section 1411(b)(4) of the federal act that such individual has changed employers; and

(ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(13) Provide to each employer the name of each employee, as described in subparagraph (B) of subdivision (12) of this section, of the employer who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(14) Perform duties required of, or delegated to, the exchange by the Secretary or the Secretary of the Treasury of the United States related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

(15) Select entities qualified to serve as Navigators in accordance with Section 1311(i) of the federal act and award grants to enable Navigators to:

(A) Conduct public education activities to raise awareness of the availability of qualified health plans;

(B) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code and cost-sharing reductions under Section 1402 of the federal act;

(C) Facilitate enrollment in qualified health plans;

(D) Provide referrals to the Office of the Healthcare Advocate or health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 USC 300gg-93, as amended from time to time, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint or question regarding the enrollee's health benefit plan, coverage or a determination under that plan or coverage; and

(E) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(16) Review the rate of premium growth within and outside the exchange and consider such information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(17) Credit the amount, in accordance with Section 10108 of the federal act, of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer;

(18) Consult with stakeholders relevant to carrying out the activities required under sections 1 to 12, inclusive, of this act, including, but not limited to:

(A) Individuals who are knowledgeable about the health care system, have background or experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans;

(B) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) Representatives of small employers and self-employed individuals;

(D) The Department of Social Services; and

(E) Advocates for enrolling hard-to-reach populations; and

(19) Meet the following financial integrity requirements:

(A) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the Insurance Commissioner and the General Assembly a report concerning such accountings;

(B) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the federal act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to:

(i) Investigate the affairs of the exchange;

(ii) Examine the properties and records of the exchange; and

(iii) Require periodic reports in relation to the activities undertaken by the exchange; and

(C) Not use any funds in carrying out its activities under sections 1 to 12, inclusive, of this act, that are intended for the administrative and operational expenses of the exchange, for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or state legislative and regulatory modifications.

Sec. 7. (NEW) (*Effective from passage*) (a) The exchange shall make qualified health plans available to qualified individuals and qualified employers for coverage beginning on or before January 1, 2014.

(b) (1) The exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code through the

exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the federal act.

(c) Neither the exchange nor a health carrier offering health benefit plans through the exchange shall charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because (1) the individual has become newly eligible for that coverage, or (2) the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code.

Sec. 8. (NEW) (*Effective from passage*) (a) The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package, as described in Section 1302(a) of the federal act, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection (e) of this section, if:

(A) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the commissioner;

(3) The plan provides at least a bronze level of coverage, as determined pursuant to subdivision (6) of section 6 of this act, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the federal act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the federal act;

(5) The health carrier offering the plan:

(A) Is licensed and in good standing to offer health insurance coverage in the state;

(B) Agrees to offer at least (i) one qualified health plan at a silver level of coverage, as determined pursuant to subdivision (6) of section 6 of this act, and (ii) one qualified health plan at a gold level of coverage, as determined pursuant to subdivision (6) of section 6 of this act, through each component of the exchange in which the health carrier participates, where "component" refers to the SHOP Exchange and the exchange for individual coverage;

(C) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange or directly by the health carrier or through an insurance producer;

(D) Does not charge any cancellation fees or penalties as set forth in subsection (c) of section 7 of this act; and

(E) Complies with the regulations developed by the Secretary under Section 1311(d) of the federal act and such other requirements as the exchange may establish;

(6) The plan meets the requirements for certification pursuant to written procedures adopted under section 3 of this act and regulations promulgated by the Secretary under Section 1311(c) of the federal act; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in the state.

(b) The exchange shall not refuse to certify a health benefit plan as a qualified health plan:

(1) On the basis that (A) the plan is a fee-for-service plan, or (B) the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly; or

(2) By conditioning such certification on the imposition of premium price controls by the exchange.

(c) The exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

(1) Agree to submit a justification for any premium increase before implementation of such increase. The health carrier shall prominently post such justification and any information related to such justification on its Internet web site. The exchange shall take such justification and information into consideration, along with any additional information and recommendations provided to the exchange by the commissioner under Section 2794(b) of the Public Health Service Act, 42 USC 300gg-94, as amended from time to time, when determining whether to allow the health carrier to continue to make such plan available through the exchange;

(2) Make available to the public in plain language, as that term is defined in Section 1311(e)(3)(B) of the federal act, and submit to the exchange, the Secretary and the commissioner, accurate and timely disclosure of the following for such plan:

(A) Claims payment policies and practices;

(B) Periodic financial disclosures;

(C) Data on enrollment;

(D) Data on disenrollment;

(E) Data on the number of claims that are denied;

(F) Data on rating practices;

(G) Information on cost-sharing and payments with respect to any out-of-network coverage;

(H) Information on enrollee and participant rights under Title I of the federal act; and

(I) Other information determined as appropriate by the Secretary; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments and coinsurance, under the individual's plan or coverage that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet web site and through other means for individuals without access to the Internet.

(d) The exchange shall not exempt any health carrier seeking certification of a health benefit plan as a qualified health plan from state licensure or reserve requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

(e) (1) The provisions of sections 1 to 12, inclusive, of this act, that are applicable to qualified health plans, shall also apply to the extent applicable to qualified dental plans, except as modified in accordance with the provisions of subdivisions (2), (3) and (4) of this subsection or by written procedures adopted by the exchange.

(2) A health carrier seeking certification of a dental benefit plan as a qualified dental plan shall be licensed in the state to offer dental coverage, but need not be licensed to offer other health benefits.

(3) Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically

offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to Section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange may specify or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same such prices.

Sec. 9. (NEW) (*Effective from passage*) The state of Connecticut does hereby pledge to, and agree with, any person with whom the exchange may enter into contracts pursuant to the provisions of sections 1 to 12, inclusive, of this act, that the state will not limit or alter the rights hereby vested in the exchange until such contracts and the obligations thereunder are fully met and performed on the part of the exchange, except that nothing in this section shall preclude such limitation or alteration if adequate provision shall be made by law for the protection of such persons entering into contracts with the exchange.

Sec. 10. (NEW) (*Effective from passage*) The exchange shall be exempt from all franchise, corporate business, property and income taxes levied by the state or any municipality, except that nothing in this section shall be construed to exempt from any such taxes, or from any taxes levied in connection with, (1) the manufacture or sale of any products that are the subject of any agreement made by the exchange, or (2) any person entering into any contract with the exchange.

Sec. 11. (NEW) (*Effective from passage*) (a) Not later than January 1, 2012, and annually thereafter until January 1, 2014, the chief executive officer of the exchange shall report, in accordance with section 11-4a of the general statutes, to the Governor and the General Assembly on a plan, and any revisions or amendments to such plan, to establish a health insurance exchange in the state. Such report shall address:

(1) Whether to establish two separate exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single exchange;

(2) Whether to merge the individual and small employer health insurance markets;

(3) Whether to revise the definition of "small employer" from not more than fifty employees to not more than one hundred employees;

(4) Whether to allow large employers to participate in the exchange beginning in 2017;

(5) Whether to require qualified health plans to provide the essential health benefits package, as described in Section 1302(a) of the federal act, or include additional state mandated benefits;

(6) The relationship of the exchange to insurance producers and agents;

(7) The capacity of the exchange to award Navigator grants pursuant to subdivision (15) of section 6 of this act; and

(8) Ways to ensure that the exchange is financially sustainable by 2015, as required by the federal act.

(b) Not later than January 1, 2012, and annually thereafter, the chief executive officer of the exchange shall report, in accordance with section 11-4a of the general statutes, to the Governor and the General Assembly on:

(1) Any private or federal funds received during the preceding calendar year and, if applicable, how such funds were expended;

(2) The amount and recipients of any grants awarded; and

(3) The current financial status of the exchange.

Sec. 12. (NEW) (*Effective from passage*) Nothing in sections 1 to 11,

inclusive, of this act, and no action taken by the exchange pursuant to said sections of this act shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance in the state. Except as expressly provided to the contrary in sections 1 to 11, inclusive, of this act, all health carriers offering qualified health plans in the state shall comply with all applicable health insurance laws of the state and regulations adopted and orders issued by the commissioner.

Sec. 13. Subsection (l) of section 1-79 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(l) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Education Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Lower Fairfield County Convention Center Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, **[**and**]** Health Information Technology Exchange of Connecticut and Connecticut Health Insurance Exchange.

Sec. 14. Subdivision (1) of section 1-120 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(1) "Quasi-public agency" means the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Health and Educational Facilities Authority, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Capital City Economic Development Authority, Connecticut Lottery Corporation, **[**and**]** Health Information Technology Exchange of Connecticut and Connecticut Health Insurance Exchange.

Sec. 15. Section 1-124 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The Connecticut Development Authority, the Connecticut Health and Educational Facilities Authority, the Connecticut Higher Education Supplemental Loan Authority, the Connecticut Housing Finance Authority, the Connecticut Housing Authority, the Connecticut Resources Recovery Authority, the Health Information Technology Exchange of Connecticut, **[**and**]** the Capital City Economic Development Authority and the Connecticut Health Insurance Exchange shall not borrow any money or issue any bonds or notes which are guaranteed by the state of Connecticut or for which there is a capital reserve fund of any kind which is in any way contributed to or guaranteed by the state of Connecticut until and unless such borrowing or issuance is approved by the State Treasurer or the Deputy State Treasurer appointed pursuant to section 3-12. The approval of the State Treasurer or said deputy shall be based on documentation provided by the authority that it has sufficient revenues to (1) pay the principal of and interest on the bonds and notes issued, (2) establish, increase and maintain any reserves deemed by the authority to be advisable to secure the payment of the principal of and interest on such bonds and notes, (3) pay the cost of maintaining, servicing and properly insuring the purpose for which the proceeds of the bonds and notes have been issued, if applicable, and (4) pay such other costs as may be required.

(b) To the extent the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, the Health Information Technology Exchange of Connecticut, **[**or**]** the Capital City Economic Development Authority or the Connecticut Health Insurance Exchange is permitted by statute and determines to exercise any power to moderate interest rate fluctuations or enter into any investment or program of investment or contract

respecting interest rates, currency, cash flow or other similar agreement, including, but not limited to, interest rate or currency swap agreements, the effect of which is to subject a capital reserve fund which is in any way contributed to or guaranteed by the state of Connecticut, to potential liability, such determination shall not be effective until and unless the State Treasurer or his or her deputy appointed pursuant to section 3-12 has approved such agreement or agreements. The approval of the State Treasurer or his or her deputy shall be based on documentation provided by the authority that it has sufficient revenues to meet the financial obligations associated with the agreement or agreements.

Sec. 16. Section 1-125 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The directors, officers and employees of the Connecticut Development Authority, Connecticut Innovations, Incorporated, Connecticut Higher Education Supplemental Loan Authority, Connecticut Housing Finance Authority, Connecticut Housing Authority, Connecticut Resources Recovery Authority, including ad hoc members of the Connecticut Resources Recovery Authority, Connecticut Health and Educational Facilities Authority, Capital City Economic Development Authority, the Health Information Technology Exchange of Connecticut, **[**and**]** Connecticut Lottery Corporation and Connecticut Health Insurance Exchange and any person executing the bonds or notes of the agency shall not be liable personally on such bonds or notes or be subject to any personal liability or accountability by reason of the issuance thereof, nor shall any director or employee of the agency, including ad hoc members of the Connecticut Resources Recovery Authority, be personally liable for damage or injury, not wanton, reckless, wilful or malicious, caused in the performance of his or her duties and within the scope of his or her employment or appointment as such director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority. The agency shall protect, save harmless and indemnify its directors, officers or employees, including ad hoc members of the Connecticut

Resources Recovery Authority, from financial loss and expense, including legal fees and costs, if any, arising out of any claim, demand, suit or judgment by reason of alleged negligence or alleged deprivation of any person's civil rights or any other act or omission resulting in damage or injury, if the director, officer or employee, including ad hoc members of the Connecticut Resources Recovery Authority, is found to have been acting in the discharge of his or her duties or within the scope of his or her employment and such act or omission is found not to have been wanton, reckless, wilful or malicious.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*from passage*	New section
Sec. 7	*from passage*	New section
Sec. 8	*from passage*	New section
Sec. 9	*from passage*	New section
Sec. 10	*from passage*	New section
Sec. 11	*from passage*	New section
Sec. 12	*from passage*	New section
Sec. 13	*from passage*	1-79(l)
Sec. 14	*from passage*	1-120(1)
Sec. 15	*from passage*	1-124
Sec. 16	*from passage*	1-125

INS	*Joint Favorable C/R*	GAE
GAE	*Joint Favorable C/R*	FIN
FIN	*Joint Favorable*	

OFA Fiscal Note

State Impact: See Below

Municipal Impact: None

Explanation

This bill creates the Connecticut Health Insurance Exchange (the Exchange). The Exchange is a quasi-public agency tasked with implementing the insurance exchange requirements of the federal Patient Protection and Affordable Care Act (PPACA).

The Exchange will have ongoing operational costs that will depend upon the administrative structures that are developed by the board. For purposes of comparison, the Commonwealth of Massachusetts (with roughly twice the population of Connecticut), established a health insurance exchange in 2007. Initial operating costs were $19.5 million in the first year and $29.9 million in the second year. However, the Massachusetts Exchange is tasked with administering a publically subsidized health insurance program, which is outside the scope of this bill. Therefore, the cost of the Connecticut exchange is likely to be proportionately less.

The bill specifies that the Exchange can charge assessments or user fees to health carriers to generate necessary funding to support operations. Connecticut has received an exchange planning grant from the federal government of $996,848. Under PPACA, additional federal funds are available to assist states in the implementation of the health insurance exchanges. A consortium of the six New England states has already been granted $35.6 million to develop an on-line gateway to health insurance options.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

SB 921

AN ACT ESTABLISHING A STATE HEALTH INSURANCE EXCHANGE.

SUMMARY:

This bill establishes the Connecticut Health Insurance Exchange, a quasi-public agency, to satisfy requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). Under the bill, a 14-member board manages the exchange, including operating an online marketplace where individuals and small employers (i.e., those with up to 50 employees) can compare and purchase health insurance plans that meet federal requirements beginning in 2014.

EFFECTIVE DATE: Upon passage

§§ 2, 13-16 — EXCHANGE CREATION

The bill creates the Connecticut Health Insurance Exchange (exchange) as a quasi-public agency and adds the exchange to the statutes governing quasi-public agencies. The exchange is not a state department, institution, or agency.

Board Membership

The bill vests the powers of the exchange in a 14-member board of directors, which includes the (1) insurance commissioner, or his designee, as an ex-officio, nonvoting member and (2) Public Health (DPH) and Social Services (DSS) department commissioners and the Office of Policy and Management (OPM) secretary, or their designees, as ex-officio, voting members. The remaining 10 voting board members must be appointed by the governor and the legislative leaders by July 1, 2011. The appointees and their respective qualifications and initial term are shown in Table 1.

Table 1: Appointed Exchange Board Members

Appointing Authority	*Qualifications*	*Initial Term*
Governor	Represents small employers	Four years
Governor	Represents labor	Three years
Governor	Represents health care providers	Two years
Governor	Represents health care consumers	One year
Senate president pro tempore	Actuary	Four years
House speaker	Health plan benefit specialist	Three years
Senate majority leader	Health care economist	Two years
House majority leader	Represents self-employed individuals	One year
Senate minority leader	Represents large employers	Four years
House minority leader	Represents health insurance industry	Three years

After initial terms expire, all subsequent terms are four years. Vacancies must be filled by the appointing authority for the rest of the term. Members can be removed by the appointing authority for misfeasance, malfeasance, or willful neglect of duty. Members are not compensated, but can be reimbursed for their expenses incurred in performing official duties.

Members may engage in private employment or in a profession or business, subject to any federal or state laws, regulations, and rules regarding ethics and conflict of interest.

The bill specifies that it does not constitute a conflict of interest for a trustee, director, partner, or officer of any person, firm, or corporation, or any individual having a financial interest in the person, firm, or corporation, to serve as an exchange board member. But such a member must abstain from any deliberation, action, or vote relating to the person, firm, or corporation.

Chairperson and Meetings. The bill requires the governor to select a board chairperson from among the members. The chairperson must hold the first board meeting by August 1, 2011. Any member who fails

to attend at least three consecutive meetings or 50% of all meetings during a calendar year is deemed to have resigned.

Chief Executive Officer. The bill requires the board to appoint a chief executive officer (CEO) who serves at the board's pleasure and is paid at the level the board sets. The CEO administers the exchange's programs and activities in accordance with the board's policies and objectives. The CEO may hire other employees as designated by the board.

Consultation. The bill allows the board to consult with public or private parties it deems necessary or desirable in performing its duties.

Advisory Committees. The bill authorizes the board to create advisory committees it deems necessary to provide input on issues, including customer service needs and insurance producer concerns.

§ 3 — WRITTEN PROCEDURES

The board must adopt written procedures in accordance with quasi-public agency law, which requires published notice before action, for:

1. adopting an annual budget and plan of operations, including a requirement of board approval before either may take effect;

2. hiring, dismissing, promoting, and compensating the exchange's employees, including an affirmative action policy and a requirement of board approval before a position may be created or a vacancy filled;

3. acquiring real and personal property and personal services, including a requirement of board approval for any nonbudgeted expenditure over $5,000;

4. contracting for financial, legal, bond, underwriting, and other professional services, including a requirement that the exchange solicit proposals at least once every three years for each service it uses;

5. issuing and retiring bonds, bond anticipation notes, and other obligations of the exchange;

6. establishing requirements for certifying qualified health plans, including minimum standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and coverage descriptions, and quality measures for health benefit plan performance; and

7. implementing the bill or other provisions of state law, provided they do not conflict with regulations adopted by the U.S. Health and Human Services (HHS) secretary.

§ 4 — FORWARDING COPY OF AUDIT

The bill requires the board to submit to the Insurance and Real Estate Committee a copy of each audit of the exchange conducted by an independent auditing firm within seven days of receiving the audit.

§ 5 — PURPOSES OF THE EXCHANGE

The bill specifies the purposes of the exchange and permits public funds to be spent to carry them out. Under the bill, the exchange can:

1. have perpetual succession as a body politic and corporate;

2. adopt bylaws;

3. adopt an official seal and alter it at pleasure;

4. establish a state office;

5. employ staff as necessary who are exempt from classified service and who are not state employees;

6. establish personnel practices and policies relating to hiring, promotion, compensation, retirement, and collective bargaining (but the exchange is not a state employer and its personnel policies need not follow the laws governing state employees);

7. engage consultants, attorneys, and other experts as necessary;

8. acquire, own, manage, hold, and dispose of real and personal property and lease, convey, deal, or enter into agreements concerning such property on any terms necessary to carry out the exchange's purposes;

9. receive and accept aid or contributions of any kind from any source;

10. charge assessments or use fees to health carriers or otherwise generate funding necessary to support the exchange;

11. obtain insurance against loss concerning its property and other assets;

12. invest its funds in U.S.- or state-issued or -guaranteed obligations and in obligations that are legal investments for savings banks in Connecticut;

13. issue, fund, or refund bonds, bond anticipation notes, and other obligations of the exchange to fund any of its corporate purposes;

14. borrow money to obtain working capital;

15. account for and audit exchange funds and any recipients of exchange funds;

16. enter into contracts or agreements necessary to perform its duties, but such contracts are not subject to approval of any state agency as long as they are made public records, subject to the proprietary rights of any party to the contract;

17. if permitted under its contracts, agree to any termination, modification, forgiveness, or other change of any term of any contractual right, payment, royalty, contract, or agreement;

18. award grants to "navigators" (see below), which may be

conditioned on the applicant's financial participation and other factors the board deems relevant;

19. sue, be sued, implead, and be impleaded;

20. adopt procedures that do not conflict with state law; and

21. do all acts necessary and convenient to carry out its purposes.

§ 6 — DUTIES OF THE EXCHANGE

Under the bill, the exchange must:

1. implement procedures for certifying, recertifying, and decertifying health benefit plans as qualified health plans, consistent with the bill and HHS guidelines;

2. operate a toll-free consumer assistance hotline;

3. provide for enrollment periods as provided in the PPACA;

4. maintain an Internet website through which people may obtain standardized comparative information on qualified health plans;

5. publish on its website the average costs of licensing, regulatory fees, and any other payments the exchange requires and the exchange's administrative costs, including information on amounts lost to waste, fraud, and abuse;

6. rate each qualified health plan offered through the exchange and determine each plan's level of coverage in accordance with HHS criteria and regulations;

7. use a standardized format for presenting health benefit options in the exchange;

8. screen applications to determine if applicants are eligible for Medicaid, the State Children's Health Insurance Program, or other state public insurance programs and enroll eligible applicants in such programs;

9. establish and make available electronically a calculator that allows individuals to determine their actual cost of coverage, taking into consideration any applicable federal premium tax credit and cost-sharing reduction;

10. establish a Small Business Health Options Program (SHOP) Exchange through which qualified employers may access coverage for their employees and specify a level of coverage so that their employees may enroll in any qualified health plan offered through the exchange at that specified level of coverage;

11. certify if an individual is exempt from the PPACA requirement to carry health insurance or from the penalty for not doing so;

12. provide to the U.S. Treasury secretary the name and taxpayer identification number of each individual (a) granted an exemption, (b) who was an employee of an employer and was eligible for the premium tax credit because the employer did not provide minimum essential health benefits coverage or provided coverage that was unaffordable or did not meet the required actuarial value, (c) who notifies the exchange he or she has changed employers, and (d) and who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

13. give each employer the name of each employee who was eligible for a premium tax credit and ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

14. determine eligibility for premium tax credits, reduced cost-sharing, or insurance purchase mandate exemptions as required by HHS or the Treasury Department;

15. review the rate of premium growth within and outside the exchange and consider that information when developing recommendations on whether to continue limiting qualified

employer status to small employers; and

16. credit the amount of any "free choice voucher" to the monthly premium of the plan in which a qualified employee is enrolled and collect the amount credited from the offering employer.

(Under PPACA, employers must offer certain employees a "free choice voucher." The employee can use the voucher to purchase a qualified health plan on the exchange.)

Navigators

The exchange must select entities qualified to serve as navigators under the PPACA and award grants to enable navigators to:

1. conduct public education activities about the availability of qualified health plans;

2. distribute fair and impartial information concerning enrollment in qualified health plans and the availability of federal premium tax credits and cost-sharing reductions;

3. facilitate enrollment in qualified health plans;

4. provide referrals to the healthcare advocate or other appropriate state agency for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or a determination under that plan or coverage; and

5. provide information in a manner that is culturally and linguistically appropriate.

Stakeholders

The exchange must consult with stakeholders relevant to implementing the bill, including:

1. enrollees in qualified health plans who are knowledgeable about the health care system and have background and experience in making informed decisions regarding health, medical, and

scientific matters;

2. people and entities with experience in facilitating enrollment in qualified health plans;

3. representatives of small employers and self-employed individuals;

4. DSS; and

5. advocates for enrolling hard-to-reach populations.

Financial Integrity

The exchange must meet the following financial integrity requirements:

1. accurately account for all activities, receipts, and expenditures and annually report on these to HHS, the governor, the insurance commissioner, and the legislature;

2. fully cooperate with any HHS investigation and allow HHS to (a) investigate the exchange's affairs, (b) examine its properties and records, and (c) require periodic reports of its activities; and

3. ensure that its funds are not spent for staff retreats, promotional giveaways, excessive executive compensation, or state or federal lobbying.

§§ 7 & 8 — QUALIFIED HEALTH PLANS

The bill requires the exchange to make qualified health plans available to qualified individuals and employers by January 1, 2014. The exchange cannot make plans available unless they are qualified health plans.

The bill defines a "qualified health plan" as a health benefit plan that is certified as meeting criteria outlined in the PPACA and this bill. A "qualified individual" is a state resident seeking to enroll in a qualified health plan offered to individuals through the exchange who

is a U.S. citizen, national, or lawful alien and not incarcerated (except for pretrial inmates). A "qualified employer" is a small employer with its principal place of business in Connecticut that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange. The employer also may elect to make some or all part-time employees eligible. The employer must provide coverage through the SHOP exchange to either all its eligible employees wherever they work or all its eligible employees employed in Connecticut.

The exchange must allow a health carrier to offer a limited scope dental plan, either separately or as part of a qualified health plan, if it covers pediatric dental benefits.

Under the bill, the exchange or a health carrier offering plans through the exchange cannot charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards.

Certifying Qualified Health Plans

The bill authorizes the exchange to certify a health benefit plan as a qualified health plan if:

1. the plan provides the federally designated essential health benefits (but a plan does not have to contain all essential health benefits if it is a qualified dental plan and the health carrier prominently discloses that (1) the plan does not provide all essential pediatric benefits and (2) qualified dental plans with those benefits are offered through the exchange);

2. the insurance commissioner has approved the premium rates and contract language;

3. the plan provides at least a "bronze" level of coverage (covering 60% of the cost of essential health benefits) unless it is certified as

a catastrophic plan and offered only to people eligible for such plans (e.g., under age 30 or exempt from the PPACA's requirement to carry health insurance);

4. the plan complies with federal limits on out-of-pocket costs;

5. the plan meets the exchange's certification requirements and those in HHS regulations; and

6. the exchange determines that making the plan available is in the interests of qualified individuals and employers in the state.

Under the bill, the exchange cannot refuse to certify a plan (1) because it is a fee-for-service plan, (2) by imposing premium price controls, or (3) because it believes the plan provides treatments to prevent patients' deaths in circumstances that are too costly or inappropriate.

The exchange cannot exempt any health carrier from state licensure or reserve requirements and must apply the certification criteria in a way that assures a level playing field among health carriers participating in the exchange.

Health Carrier Requirements. To be eligible to offer qualified health plans through the exchange, a health carrier must:

1. be licensed and in good standing to offer health insurance in Connecticut;

2. offer through the exchange at least one plan at the "silver" coverage level (covering 70% of the cost of essential health benefits) and one plan at the "gold" coverage level (covering 80% of the cost of essential health benefits) through each exchange in which it participates (i.e., the exchange for individuals and the SHOP exchange);

3. charge the same premium rate for each qualified health plan whether offered (a) through the exchange or outside it or (b)

directly by the carrier or through an insurance producer;

4. not charge an individual a coverage termination fee or penalty if the individual enrolls in another type of minimum essential coverage because he or she is newly eligible for the coverage or the individual's employer-sponsored coverage has become affordable under federal standards; and

5. comply with HHS regulations and any other requirements the exchange may establish.

A health carrier must agree to submit (presumably to the exchange) and post on its website a justification for any premium increase before implementing the increase. (The bill does not specify how long before implementing an increase the carrier must submit this information.) The exchange must consider such justification, along with any additional information from the insurance commissioner, when determining whether to allow the carrier to continue making the plan available through the exchange.

A health carrier must disclose information in plain language to the public, the exchange, HHS, and the insurance commissioner including information regarding claims, finances, enrollment, rating practices, out-of-network coverage cost sharing, enrollee rights under PPACA, and other information HHS requires.

A health carrier also must inform individuals, upon request, of the amount of cost sharing (e.g., deductibles, copayments, and coinsurance) the individuals are responsible for under their plans for specific services.

Qualified Dental Plans. The bill applies, to the extent applicable, to qualified dental plans, except as modified by the exchange's adopted, written procedures or the following:

1. a health carrier seeking certification of a dental plan as a qualified dental plan must be licensed in Connecticut to offer dental coverage but does not need to be licensed to offer other

health benefits;

2. qualified dental plans are limited to dental and oral health benefits and must include, at a minimum, the essential pediatric dental benefits defined by HHS and other dental benefits as the exchange or HHS may specify; and

3. health carriers may jointly offer a comprehensive plan through the exchange in which dental benefits are provided by one carrier and health benefits by another carrier, as long as the plans are qualified plans and priced and made available for purchase separately.

§ 9 — STATE PLEDGE REGARDING CONTRACTUAL OBLIGATIONS

Under the bill, the state pledges that it will not limit or alter any rights vested in the exchange until the exchange's contractual obligations to any person are fully met. But nothing precludes limitation or alteration if adequate provision is made by law to protect those entering into contracts with the exchange.

§ 10 — TAX EXEMPTION

The bill exempts the exchange from state and municipal franchise, corporate business, property, and income taxes. But it does not exempt (1) a person entering into a contract with the exchange from the taxes or (2) the exchange from any manufacture or sales taxes.

§ 11 — ANNUAL REPORTING REQUIREMENTS

The bill requires the exchange's CEO to report to the governor and legislature by January 1, 2012, 2013, and 2014, on the exchange in Connecticut. The report must address whether to:

1. establish separate exchanges for individuals and small employers or one combined exchange;

2. merge the individual and small employer health markets;

3. revise the definition of "small employer" from 50 to 100

employees;

4. allow large employers to participate in the exchange starting in 2017; and

5. require qualified health plans to provide only the federally defined essential health benefits package or also include additional state mandated benefits.

The report also must address:

1. the relationship between the exchange and insurance producers;

2. the exchange's capacity to award navigator grants; and

3. ways to ensure the exchange is financially sustainable by 2015 (as required by PPACA).

The bill also requires the exchange's CEO to report to the governor and legislature annually, beginning January 1, 2012, on:

1. any private or federal funds received during the prior calendar year and how they were spent;

2. the amounts and recipients of any grants awarded (presumably navigator grants); and

3. the exchange's current financial status.

§ 12 — INSURANCE COMMISSIONER'S AUTHORITY

The bill and the exchange's actions do not preempt or supersede the insurance commissioner's authority to regulate insurance in Connecticut. Unless expressly provided to the contrary in the bill, all health carriers offering qualified health plans in Connecticut must comply with all applicable state health insurance laws and regulations and insurance commissioner's orders.

BACKGROUND

Related Bills

The Insurance and Real Estate Committee reported out HB 6323, which similarly creates an exchange as a quasi-public agency.

The Public Health Committee reported out sSB 1204, which similarly creates an exchange as a quasi-public agency.

COMMITTEE ACTION

Insurance and Real Estate Committee

House Favorable Change of Reference
Yea 16 Nay 1 (03/10/2011)

Insurance and Real Estate Committee

Joint Favorable Change of Reference
Yea 16 Nay 1 (03/10/2011)

Government Administration and Elections Committee

Joint Favorable Change of Reference
Yea 11 Nay 2 (03/23/2011)

Finance, Revenue and Bonding Committee

Joint Favorable
Yea 34 Nay 18 (04/07/2011)